Form B1: Contact initial reporting form – for close contacts (Day 1)

The First Few X (FFX): Cases and contact investigation protocol for 2019-nCoV

2- For close contacts

Form B1: Contact initial reporting form – for close contacts (Day 1)

Confirmed Case ID / Cluster Number (if applicable):

Contact ID Number (C…):
Note: Contact ID numbers should be issued at the time of completion of Form A1.

Name of confirmed case

1. Data Collector Information	
Name of data collector	
Data collector Institution	
Phone number	
Email	
Form completion date (dd/mm/yyyy)	___/___/___

2. Interview respondent information (if the persons providing the information is not the contact)	
First name	
Surname	
Sex	□ Male □ Female □ Not known
Date of Birth	___/___/___
Relationship to patient	
Respondent address	
Telephone (mobile) number	

3. Contact Details (Details of the contact)	
Given name(s)	
Family name	
Sex	□ Male □ Female □ Not known
Date of Birth	___/___/___
Relationship to case	
Address (village/town, district, province/region)	
Telephone number	
Email address	
Preferred mode of contact	□ Mobile □ Work □ Home □ Email
Nationality	
Country of residence	
National social number/ identifier (optional)	
Have you travelled within the last 14 days domestically?	□ Yes □ No □ Unknown

	If Yes, dates of travel (DD/MM/YYYY): ___/___/___ to ___/___/___ Regions: Cities visited:
Have you travelled within the last 14 days internationally?	□ Yes □ No □ Unknown If Yes, dates of travel (DD/MM/YYYY): ___/___/___ to ___/___/___ Countries visited: Cities visited:
In the past 14 days, have you had contact with a anyone with suspected or confirmed 2019-nCoV infection?	□ Yes □ No □ Unknown If Yes, dates of last contact (DD/MM/YYYY): ___/___/___
Occupation (specify location/facility)	□ Health care worker □ Working with animals □ Health laboratory worker □ Student □ Other, specify: For each occupation, please specify location or facility:______________________________________

Note for next 2 sections:

- **Complete Section 4** if the contact is a Health Care Worker (HCW)**.**
- **Complete Section 5** if the contact is**.** NOT a Health Care Worker (HCW)

4 Exposure Information (if the close contact is a <u>Health Care Worker</u>)	
Job title (specify)	
Place of work	
Direct physical contact with the confirmed case (e.g. hands-on physical contact)	□ Yes □ No
Has the HCW had prolonged face-to-face contact (>15 minutes) with a <u>symptomatic</u> confirmed case in an health facility?	□ Yes □ No If yes, what type of protective equipment was used by the health care worker? □ Gown □ Surgical/medical mask □ Gloves □ NIOSH-CERTIFIED N95, AN EU STANDARD FFP2 □ FFP3 □ Eye protection
Has the HCW had prolonged face-to-face contact (>15 minutes) with an <u>asymptomatic</u> confirmed case in a health facility?	□ Yes □ No If yes, What type of protective equipment was used by the health care worker?

	□ Gown □ Surgical/medical mask □ Gloves □ NIOSH-CERTIFIED N95, AN EU STANDARD FFP2 □ FFP3 □ Eye protection
Was the contact present while any aerosol generating procedures took place?	□ Yes □ No If yes, specify procedure and date Procedure: ___/___/___ Procedure: ___/___/___ Was the contact wearing any type of a mask at this/these procedures? □ Surgical/medical □ NIOSH-CERTIFIED N95, AN EU STANDARD FFP2 □ FFP3 □ None

5. Exposure Information **(if the close contact is NOT a HealthCare Worker)**		
Type of contact	□ Household □ Other, specify: ____________	
State dates of contact and duration of contact with the confirmed case from first contact, while the primary case was **symptomatic** (Add as many dates, as required)	Date	__/__/___(dd/mm/yyyy)
	Duration	______(mins)
	Setting	□ Home/ household □ Hospital / health care □ Workplace □ Tour group □ Other, specify:_______
State dates of contact and duration of contact with the confirmed case from first contact, while the primary case was **asymptomatic** (Add as many dates, as required)	Date	__/__/___ (dd/mm/yyyy)
	Duration	________(mins)
	Setting	□ Home/ household □ Hospital / health care □ Workplace □ Tour group □ Other, specify: _________

6a. Symptoms in contact	
Has the contact experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period from 10 days before onset in the confirmed case until the present?	□ Yes □ No
Has the contact experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period up to 10 days after last contact or until the present date, whichever is the earliest?	□ Yes □ No
Currently ill	□ Yes □ No
Date and time of first symptom onset	___/___/___ □ AM □ PM
Maximum temperature	°C □ NA
6b. Respiratory symptoms	
Sore throat	□ Yes □ No □ Unknown If yes, date ___/___/___
Cough	□ Yes □ No □ Unknown If yes, date ___/___/___
Runny nose	□ Yes □ No □ Unknown
Shortness of breath	□ Yes □ No □ Unknown If yes, date ___/___/___
6c. other symptoms	
Chills	□ Yes □ No □ Unknown
Vomiting	□ Yes □ No □ Unknown
Nausea	□ Yes □ No □ Unknown
Diarrhea	□ Yes □ No □ Unknown
Headache	□ Yes □ No □ Unknown
Rash	□ Yes □ No □ Unknown
Conjunctivitis	□ Yes □ No □ Unknown
Muscle aches	□ Yes □ No □ Unknown
Joint ache	□ Yes □ No □ Unknown
Loss of appetite	□ Yes □ No □ Unknown
Nose bleed	□ Yes □ No □ Unknown
Fatigue	□ Yes □ No □ Unknown
Seizures	□ Yes □ No □ Unknown
Altered consciousness	□ Yes □ No □ Unknown
Other neurological signs	□ Yes □ No □ Unknown If Yes, specify:
Other symptoms	□ Yes □ No □ Unknown If yes, specify:

7. Outcome/status of contact (Only complete if contact has been ill or is currently ill)	
Status	□ Recovered, if yes specify date symptoms resolved ___/___/___ □ Still ill □ Dead, if yes specify date of death ___/___/___ □ Unknown/ Lost to follow-up

Hospitalization ever required?	□ Yes □ No □ Not Unknown If yes, date of hospitalization and date of discharge (dd/mm/yyyy) ___/___/___ - ___/___/___
(NB. If the information below is not currently available, please leave blank and send through an update as soon as results are available)	
If dead, contribution of 2019-nCoV to death:	□ Underlying/primary □ Contributing/secondary □ No contribution to death □ Unknown
If dead, was a port-mortem performed?	□ Yes □ No □ Unknown
If dead, cause of death on Death certificate (specify)	
If dead, results of post-mortem's report where available:	

8. Contact pre-existing condition(s)	
Pregnancy	□ Yes □ No □ Unknown If yes, specify trimester: □ First □ Second □ Third □ NA
Obesity	□ Yes □ No □ Unknown
Heart disease	□ Yes □ No □ Unknown
Asthma requiring medication	□ Yes □ No □ Unknown
Chronic lung disease (non-asthma)	□ Yes □ No □ Unknown
Chronic liver disease	□ Yes □ No □ Unknown
Chronic haematological disorder	□ Yes □ No □ Unknown
Chronic kidney disease	□ Yes □ No □ Unknown
Chronic neurological impairment/disease	□ Yes □ No □ Unknown
Organ or bone marrow recipient	□ Yes □ No □ Unknown
Other pre-existing condition(s)	□ Yes □ No □ Unknown If yes, specify:
Comments if appropriate	

9a. Virology testing methods and results:

Complete a new line for each specimen collected and each type of test done:

Lab identification number	**Date Sample collected (dd/mm/yyyy)**	**Date Sample Received (dd/mm/yyyy)**	**Type of Sample**	**Type of test**	**Result**	**Result Date (dd/mm/yyyy)**	**Specimens shipped to other laboratory for confirmation**
	___/___/___	___/___/___	□ Nasal swab □ Throat swab □ Nasopharyngeal swab □ Others, specify:	□ PCR □ Whole genome sequencing □ Partial genome sequencing □ Other, specify	□ POSITIVE for 2019-nCoV □ NEGATIVE for 2019-nCoV □ POSITIVE for others pathogens Please specify which pathogens: ….	___/___/___	□ Yes If yes, specify Date ___/___/___ If yes, name of the laboratory: _____ □ No

9b. Serology testing methods and results:

Complete a new line for each specimen collected and each type of test done:

Lab identification number	**Date Sample collected (dd/mm/yyyy)**	**Date Sample Received (dd/mm/yyyy)**	**Type of Sample**	**Type of test**	**Result** (2019-nCoV antibody titres)	**Result date (dd/mm/yyyy)**	**Specimens shipped to other laboratory for confirmation**
	___/___/___	___/___/___	□ Serum □ Others, specify:	Specify type (ELISA / IFA IgM/ IgG, Neutralization assay, etc): ____	□ POSITIVE If positive, titre : ____ □ NEGATIVE □ INCONCLUSIVE	___/___/___	□ Yes If yes, specify Date ___/___/___ If yes, name of the laboratory: _____ □ No

10. Status of form completion	
Form completed	□ Yes □ No or partially If no or partially, reason : □ Missed □ Not attempted □ Not performed □ Refusal □ Other, specific: